

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10669

10683

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Routel</u>				d. STREET ADDRESS <u>Rt 1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Rosetta</u> First <u>Askins</u> Middle <u>Askins</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/1880</u> 76 yrs.	
9. AGE (In years lost birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min. <u>56</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Turner</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Rozier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>L</u> (If yes, give war or dates of service) <u>L</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma Copper, Trappe</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>591X</u> DUE TO <u>Acute parenchymatous nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3-4 months</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>56</u> , to <u>Oct 12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Oct 12</u> , 19 <u>56</u> and that death occurred at <u>Trappe, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hayward P. Wetzel, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Trappe, Md.</u> DATE SIGNED <u>Oct 10, 1956</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/16/56</u>		<u>Trappe, Cem</u>		<u>Trappe Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Trappe, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>N. H. Newen</u>	
DATE <u>10/15/56</u>							

BUREAU V. 81

1956 18 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10671

10669

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Federal Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>LANE</u> Last <u>CARROLL</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Lane</u>				14. MOTHER'S MAIDEN NAME <u>Anna belle Espey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mr Raymond Carroll (husband)</u> Address			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cabasic aortic stenosis</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. 20021 N.E.B.</u> DATE SIGNED <u>10/22/56</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				M.D. <u>E. A. B. Orthman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. Newman</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/22/56</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Newlin</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		BUSINESS		OTHER		DATE OF OCCUPATION		PLACE OF OCCUPATION	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF EDUCATION		PLACE OF EDUCATION		CITY OF EDUCATION		STATE OF EDUCATION	
RELIGION		METHODIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER		DATE OF RELIGION		PLACE OF RELIGION	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF OTHER		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	

BUREAU V. 2

OCT 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10672	
Item 20 Film G205 10-22-56 ams											
10684											
CERTIFICATE OF DEATH										Reg. Dist. No. 290	
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>					c. LENGTH OF STAY IN 1b <u>18 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>CAULK</u> Last <u>CAULK</u>					4. DATE OF DEATH		Month <u>10</u> Day <u>4</u> Year <u>1956</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23, 1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM BURNS</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH GRAHAM</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Vera Lubech (daughter)</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure - A.S.V.D.</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial collapse - shock -</u> (c) <u>Fracture - intertrochanteric - left hip</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>										INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>16 days</u> <u>16 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while walking across living room, turned, slipped on floor</u>						
20c. TIME OF INJURY Hour <u>a. ft.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.					20d. INJURY OCCURRED <u>2</u> While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sept 18, 1956</u> to <u>Oct 4, 1956</u> , that I last saw the deceased alive on <u>Oct 4, 1956</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.										DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u>					M.D. <u>St Michaels md</u>						
PHYSICIAN'S NAME (Type) <u>Wm M Becker</u>					<u>10-6-56</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Oct 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwamberton Harrison</u>					ADDRESS <u>St Michaels md</u>		24a. REC'D BY REGISTRAR <u>10/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Neer</u>		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES A. BROWN		Male		45		1910		BALTIMORE, MD.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
October 11, 1956		10:30 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signatures]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF DECEASED		21. FULL NAME OF DECEASED		22. FULL NAME OF DECEASED		23. FULL NAME OF DECEASED		24. FULL NAME OF DECEASED	
[Name]		[Name]		[Names]		JAMES A. BROWN		JAMES A. BROWN		JAMES A. BROWN		JAMES A. BROWN		JAMES A. BROWN	

BUREAU A. 11

OCT 11 1956

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RECEIVED
 DIVISION OF VITAL RECORDS
 BALTIMORE, MARYLAND
 OCT 11 1956
 [Illegible text]

TO HOSPITAL **22** ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G205 10-22-56 ars

CERTIFICATE OF DEATH

Reg. Dist. No.

10673
290

10685

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Easton				c. LENGTH OF STAY IN 1b entire life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) BESSIE M. DULIN				4. DATE OF DEATH Month October 1, 1956 Day 19 Year 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Theodore M. Jones				14. MOTHER'S MAIDEN NAME Elizabeth M. Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT George O. Dulin Easton, (rural) Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Colloid Goiter 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1946 , to 10/1/56 , that I last saw the deceased alive on 9/1/56 , and that death occurred at 2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M. C. Cox M.D. Easton Md PHYSICIAN'S NAME (Type) Dr. P. Evans Cox 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Oct. 3, 1956 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery 22d. LOCATION (City, town, or county) (State) Easton, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son ADDRESS Easton, Maryland 24a. REC'D BY REGISTRAR DATE 10/3/56 24b. REGISTRAR'S SIGNATURE N. H. Newnam							

BUREAU V. S.

1956 8 100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY QUEEN ANNE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WYE MILLS			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD QUEENSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEON First FLAMER Last				4. DATE OF DEATH Month DCT Day 6 Year 19 56			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/24/31	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Freddie Flamer				14. MOTHER'S MAIDEN NAME Loleda Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Loleda Flamer Address Wye Mills, R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Comp. Comm. fracture skull DUE TO auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) car struck guard rail, spun violently					
20c. TIME OF INJURY Month, Day, Year 10-6 1956 Hour: 6:45 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 50		20f. (City or town) (County) (State) nr Wye Mills Tal. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Louis S. Welty</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Louis S. Welty				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-7-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORY Cornwall Cem.		22d. LOCATION (City, town, or county) (State) Wye Mills R.F.D. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Doherty</i>				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 15 1956	
24b. REGISTRAR'S SIGNATURE <i>Mrs. N. J. Jones</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
DEATH CERTIFICATE

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES M. WILSON		45		M		W		1890		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MARRIED		1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MANUFACTURER		1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HEART DISEASE		1935		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
NATURAL		1935		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNED		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES M. WILSON		1935		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. 2
OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10687

Reg. Dist. No.

11760
11760
291

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Neavitt			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Atkin Gentzler				4. DATE OF DEATH Month Day Year October 31, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1860	9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) United Wall Paper Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Abraham Gentzler				14. MOTHER'S MAIDEN NAME Sarah Joseph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. Lucy Keesey Neavitt, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic Cardiovascular Dis DUE TO (b) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Sept , 19 55 , to 31 October , 19 56 , that I last saw the deceased alive on 10-15 , 19 56 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Lane Wroth M.D.				ADDRESS (Street, city or town, state) St. Michaels, Maryland			
PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth				DATE SIGNED 11-1-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) York, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE 11/5/56	
				24b. REGISTRAR'S SIGNATURE Wm. R. R. Scott			

MAKING AND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1956 31 AUG

RECEIVED

10670 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Greeneboro St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Bena Turner Greeneborough</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb. 7, 1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Home</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot County Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Nicholas Greeneborough</u>				14. MOTHER'S MAIDEN NAME <u>Marion Turner Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Richard Greeneborough, Easton</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A)				<u>Cerebral thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>cerebral atherosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Essential hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19 <u>52</u> , to <u>1964</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>15 Oct</u> , 19 <u>52</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thurman Haman</u>				ADDRESS (Street, city, town, state) <u>Carlton, Maryland</u> DATE SIGNED <u>16 Oct 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Oct 17, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Knolls</u>		LOCATION (City, town, or county) (State) <u>Easton MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>N. H. Newman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Greeneborough</u> ADDRESS			
DATE <u>10/17/56</u>							

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (Town or City)

2. SEX

3. AGE

4. OCCUPATION

5. DATE

6. PLACE OF DEATH (House, Hospital, etc.)

7. CAUSE

8. MANNER

9. TIME

10. SIGNATURE

11. NAME

12. ADDRESS

13. CITY

14. STATE

15. COUNTY

16. ZIP

17. MEDICAL CERTIFICATION

18. SIGNATURE OF PHYSICIAN

19. DATE

20. TIME

21. PLACE

22. CITY

23. STATE

24. COUNTY

25. ZIP

BUREAU V. 2

101 22 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10671
CERTIFICATE OF DEATH

10676

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>10 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>507 Gay Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>E</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Choptank Electric Corp</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>			
13. FATHER'S NAME <u>Eli Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Stutzman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> <u>World War #2</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Anna Harrison</u> Address <u>507 Gay St. Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarct</u> <u>181X</u> DUE TO <u>Mitosis from Carcinoma of bladder.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>10-5</u> , 19 <u>56</u> to <u>10-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>56</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>217 W. ...</u> ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>10/15/56</u>			
PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u>				ADDRESS <u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) <u>Denton, Md</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>10/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

OCT 22 1956

BUREAU V. S.

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10677

10688

Reg. Dist. No. 291

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Talbot	MARYLAND	STATE Maryland	COUNTY Talbot
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. Michaels, Md.	LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. Michaels,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Addie Oliva Kirby		4. DATE OF DEATH (Month) (Day) (Year) 10 22 1956	
5. SEX F	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 12/28/1899
9. AGE last birthday 56 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) St. Michaels, Talbot, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Andrew J. Barnett		14. MOTHER'S MAIDEN NAME Bertha Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Andrew J. Barnett			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)		Several Effusions Carcinoma of Breast	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH 3 mon 10 mon	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1956, to 22 Oct 1956, that I last saw the deceased alive on 20 Oct 1956, and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
SIGNATURE R. Hane Wrath		DATE SIGNED 10-25-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/25/56	
NAME OF CEMETERY OR CREMATORY Old Cemetery		LOCATION (City, town, or county) (State) St. Michaels, Talbot Md.	
24. REC'D BY REGISTRAR DATE Oct 25/56		REGISTRAR'S SIGNATURE Mrs Robert L. Seck	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS St. Michaels, Md.			

CERTIFICATE OF DEATH

10038

DATE OF DEATH

1. NAME OF DECEASED

2. SEX
3. AGE
4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

21. SIGNATURE OF CITY

22. SIGNATURE OF TOWNSHIP

23. SIGNATURE OF PARISH

24. SIGNATURE OF VILLAGE

25. SIGNATURE OF HAMLET

26. SIGNATURE OF CENSUS TRACT

27. SIGNATURE OF BLOCK

28. SIGNATURE OF HOUSE

29. SIGNATURE OF ROOM

30. SIGNATURE OF PLACE

1. NAME OF DECEASED

2. SEX
3. AGE
4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

21. SIGNATURE OF CITY

22. SIGNATURE OF TOWNSHIP

23. SIGNATURE OF PARISH

24. SIGNATURE OF VILLAGE

25. SIGNATURE OF HAMLET

26. SIGNATURE OF CENSUS TRACT

27. SIGNATURE OF BLOCK

28. SIGNATURE OF HOUSE

29. SIGNATURE OF ROOM

30. SIGNATURE OF PLACE

BUREAU V. S.

OCT 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10672

CERTIFICATE OF DEATH

10678

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			d. STREET ADDRESS <u>Preston</u>		
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>H</u> Middle <u>McMahon</u> Last			4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1891</u>		9. AGE (In years lost birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John H. McMahon</u>			14. MOTHER'S MAIDEN NAME <u>Annie Allen</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unknown</u>		
17. INFORMANT <u>Mrs. Sophie McMahon</u> Address <u>Preston Md.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>glioblastoma multiforme</u> 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>20 Oct 1956</u> to <u>31 Oct 1956</u> , that I last saw the deceased alive on <u>31 Oct 1956</u> , and that death occurred at <u>8:20 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.			ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED		
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-31-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Order</u>		22d. LOCATION (City, town, or county) (State) <u>Caroline Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Thompson</u> ADDRESS <u>Federalburg Md.</u>			24a. REC'D BY REGISTRAR <u>10/31/56</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>		

BUREAU V. S.

NOV 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 10673 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10679

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, Md.</u>				c. LENGTH OF STAY IN 1b <u>18 hrs - 5 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>Easton, Md. - Rt #1</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Mooney</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Philip Mooney</u>				14. MOTHER'S MAIDEN NAME <u>Annie Blackwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-26-5716</u>		17. INFORMANT <u>Ada B. Goldsborough - daughter</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from left middle cerebral artery</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:35</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. K. K. K.</u> M.D. <u>Easton, Md.</u>				ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>10/12/56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coppersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Coppersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam, Son</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 10/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newnam</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

10689

CERTIFICATE OF DEATH

Reg. Dist. No.

10680

291

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		
c. LENGTH OF STAY IN 1b 11 Mos. 9 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Bruce Middle James Last Murphy		4. DATE OF DEATH Month Oct Day 13 Year 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 4, 1955	
9. AGE (In years last birthday) yrs. 11 Months 9 Days 9 Hours 11 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Samuel Thomas Murphy		14. MOTHER'S MAIDEN NAME Anna Mae Hoover		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT Samuel T. Murphy, Tilghman, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (Found dead in bed) DUE TO Myocardial infarction - Spinal bifida. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple sclerosis DUE TO congenital anomaly (c)				INTERVAL BETWEEN ONSET AND DEATH 1 minute 11 mo 8 day 11 mo 9 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Born with spinal bifida. Part of operation				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Nov 30, 1955 to Oct 13, 1956 , that I last saw the deceased alive on Oct 13, 1956 , and that death occurred at 5 A M, from the causes and on the date stated above.				
ACTUAL SIGNATURE GUY M REESER Sr M.D.		ADDRESS (Street, city or town, state) Tilghman Md DATE SIGNED Oct 19 1956		
PHYSICIAN'S NAME (Type) GUY M REESER Sr				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/56	22c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist	22d. LOCATION (City, town, or county) (State) Tilghman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Moore Tilghman Md		24a. REC'D BY REGISTRAR 18 1956 24b. REGISTRAR'S SIGNATURE Mrs E W Smith		

2080224395

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10674 CERTIFICATE OF DEATH

10681

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>119 Hammond Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Keith Darnell Potter</u>				4. DATE OF DEATH Month Day Year <u>October 19 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-29-56</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Otis Malcolm Blake</u>				14. MOTHER'S M maiden name <u>Betty Lou Potter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u></u>		17. INFORMANT Address <u>Betty Lou Potter 119 Hammond St. Easton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>561.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulated scrotal hernia, right</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>10:15 PM</u> , 19 <u>56</u> , to <u>10:15 PM</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10:15 PM</u> , 19 <u>56</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>205 Washington St Easton, Maryland 200456</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Daniel, Easton, md</u>				24a. REC'D BY REGISTRAR DATE <u>10/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

2080243xv2

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. OCCUPATION		12. EDUCATION		13. RELIGION		14. MARITAL STATUS		15. SOCIAL STATUS	
16. PRESENT ADDRESS		17. PREVIOUS ADDRESS		18. PRESENT RESIDENCE		19. PREVIOUS RESIDENCE		20. PRESENT OCCUPATION	
21. PRESENT RESIDENCE		22. PREVIOUS RESIDENCE		23. PRESENT OCCUPATION		24. PREVIOUS OCCUPATION		25. PRESENT RESIDENCE	
26. PREVIOUS RESIDENCE		27. PRESENT OCCUPATION		28. PREVIOUS OCCUPATION		29. PRESENT RESIDENCE		30. PREVIOUS RESIDENCE	
31. PRESENT RESIDENCE		32. PREVIOUS RESIDENCE		33. PRESENT OCCUPATION		34. PREVIOUS OCCUPATION		35. PRESENT RESIDENCE	
36. PREVIOUS RESIDENCE		37. PRESENT OCCUPATION		38. PREVIOUS OCCUPATION		39. PRESENT RESIDENCE		40. PREVIOUS RESIDENCE	
41. PRESENT RESIDENCE		42. PREVIOUS RESIDENCE		43. PRESENT OCCUPATION		44. PREVIOUS OCCUPATION		45. PRESENT RESIDENCE	
46. PREVIOUS RESIDENCE		47. PRESENT OCCUPATION		48. PREVIOUS OCCUPATION		49. PRESENT RESIDENCE		50. PREVIOUS RESIDENCE	
51. PRESENT RESIDENCE		52. PREVIOUS RESIDENCE		53. PRESENT OCCUPATION		54. PREVIOUS OCCUPATION		55. PRESENT RESIDENCE	
56. PREVIOUS RESIDENCE		57. PRESENT OCCUPATION		58. PREVIOUS OCCUPATION		59. PRESENT RESIDENCE		60. PREVIOUS RESIDENCE	
61. PRESENT RESIDENCE		62. PREVIOUS RESIDENCE		63. PRESENT OCCUPATION		64. PREVIOUS OCCUPATION		65. PRESENT RESIDENCE	
66. PREVIOUS RESIDENCE		67. PRESENT OCCUPATION		68. PREVIOUS OCCUPATION		69. PRESENT RESIDENCE		70. PREVIOUS RESIDENCE	
71. PRESENT RESIDENCE		72. PREVIOUS RESIDENCE		73. PRESENT OCCUPATION		74. PREVIOUS OCCUPATION		75. PRESENT RESIDENCE	
76. PREVIOUS RESIDENCE		77. PRESENT OCCUPATION		78. PREVIOUS OCCUPATION		79. PRESENT RESIDENCE		80. PREVIOUS RESIDENCE	
81. PRESENT RESIDENCE		82. PREVIOUS RESIDENCE		83. PRESENT OCCUPATION		84. PREVIOUS OCCUPATION		85. PRESENT RESIDENCE	
86. PREVIOUS RESIDENCE		87. PRESENT OCCUPATION		88. PREVIOUS OCCUPATION		89. PRESENT RESIDENCE		90. PREVIOUS RESIDENCE	
91. PRESENT RESIDENCE		92. PREVIOUS RESIDENCE		93. PRESENT OCCUPATION		94. PREVIOUS OCCUPATION		95. PRESENT RESIDENCE	
96. PREVIOUS RESIDENCE		97. PRESENT OCCUPATION		98. PREVIOUS OCCUPATION		99. PRESENT RESIDENCE		100. PREVIOUS RESIDENCE	

BUREAU V. S.

OCT 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10690

CERTIFICATE OF DEATH

10683

Reg. Dist. No.

290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Carroll Roe</u>				4. DATE OF DEATH Month Day Year <u>Oct. 23 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12-1881</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>11 11</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Roe</u>				14. MOTHER'S MAIDEN NAME <u>Clara Stoops</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-14-9101</u>		17. INFORMANT Address <u>Mrs Minnie Roe, Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>12-23-1956</u> , that I last saw the deceased alive on <u>10/20/1956</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>10/24/56</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 26-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>				24a. REC'D BY REGISTRAR DATE <u>10/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. D. Herrie</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. M.

NOV 2 1956

RECEIVED

Vertical text on the right edge of the page, likely a filing or processing stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>-</u>			
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Sampson</u> Last <u>-</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sampson</u>				14. MOTHER'S MAIDEN NAME <u>Leman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Joe Sampson Jr. Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> (c) <u>Atherosclerosis C-V disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. p.</u> Month <u>19</u> Day <u>-</u> Year <u>-</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>56</u> , to <u>10/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>56</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Harrison</u>				DATE SIGNED <u>October 12, 1956</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				<u>EASTON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashell, Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newlin</u>	

CERTIFICATE OF DEATH

BUREAU V. 8

OCT 22 1956

RECEIVED

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signature. The form is filled out with handwritten text, including the name "William" and the date "October 22, 1956".

Vertical text on the right margin, possibly a filing stamp or reference number.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

290

10676

Form 9 Film 206 11-7-56 et

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Shes 50min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Rte 1 N 17 1/2 miles</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Schoolfield</u> Last <u>Schoolfield</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx.</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u> Hours <u>19</u> Min. <u>56</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea food worker</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence Schoolfield</u>	
14. MOTHER'S MAIDEN NAME <u>Henricetta Selby</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>825 X</u>		17. INFORMANT <u>Fannie Schoolfield (sister)</u> Address <u>Crisfield Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures abdomen</u> 825 X DUE TO (b) <u>Contusion of sub-occipital bone by</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Automobile</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov 1, 1956</u>	<u>Lansonia Cemetery</u>	<u>Crisfield Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Bradshaw and Sons, Crisfield, Md</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages may be retained for your files. Give Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 1971

NOV 2 1956

BUREAU V.

RECEIVED

10677

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Sellers</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1902</u> 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mr. George Lambdin</u>		14. MOTHER'S MAIDEN NAME <u>Nora Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Willis Sellers, (son)</u>		Address <u>Denton, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X Premia</u> DUE TO (b) <u>Bilateral uterine obstruction</u> DUE TO (c) <u>Metastatic Epidermoid Ca. of Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>3 mos</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>27 Aug</u> , 19 <u>56</u> , to <u>3 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 Oct</u> , 19 <u>56</u> , and that death occurred at <u>1100 P</u> .M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Tyler Baker</u> M.D.		ADDRESS (Street, city or town, state) <u>11 Earle Ave. Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>		DATE SIGNED <u>3 Oct 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 6 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cliff Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St Michaels MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hamilton Harrison</u>		ADDRESS <u>St Michaels Md.</u>	
24a. REC'D BY REGISTRAR <u>N.H. Newer</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newer</u>	
DATE <u>10/6/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10687

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>20 min</u>		c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) <u>Snow Hill</u> 238-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS 			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>W.</u> Last <u>Shockley</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 22, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov. Shop.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>			
12. CITIZEN OF WHAT COUNTRY? 		13. FATHER'S NAME <u>Aurelius P. Shockley</u>					
14. MOTHER'S MAIDEN NAME <u>Sadie E. Lerdy</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Lola J. Shockley - Snow Hill Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fract skull, ribs, femur, leg, arm</u> DUE TO (b) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year <u>10-8-1956</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 50 + 404</u>		20f. (City or town) <u>nr Nepe Mills Tal</u> (County) <u>Ind</u> (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis S. Welty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-8-56</u>			
EXAMINER'S NAME (Type) <u>Louis S. Welty</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Memorial</u>			
22d. LOCATION (City, town, or county) <u>Snow Hill Ind</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>W.H. Newlin</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		ADDRESS <u>Snow Hill, Ind</u>		DATE <u>10/10/56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		10/15/56		BOSTON, MASS.	
RESIDENT OF		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
100 N. ST.		10/10/11		MASS.		BOSTON		MASS.		U.S.A.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		POST-MORTEM	
LABORER		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		NO	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER	
10/15/56		J. J. JONES		M.D.		10/15/56		J. J. JONES		M.D.	
FAMILY PHYSICIAN		DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		SIGNATURE OF EXAMINER	
J. J. JONES		10/15/56		J. J. JONES		M.D.		10/15/56		J. J. JONES	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER	
10/15/56		J. J. JONES		M.D.		10/15/56		J. J. JONES		M.D.	

BUREAU V. 3

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10688

10679

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>		c. LENGTH OF STAY IN 1b <u>15 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital.</u>				d. STREET ADDRESS <u>988 Nausum St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nelson</u> First Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Mr. Arthur J. Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Alma Lyons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred James Lester</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of larynx</u> <u>1998</u> DUE TO <u>larynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Talbot Co.</u> , 19 <u>1902</u> , to <u>1956</u> , that I last saw the deceased alive on <u>1956</u> , and that death occurred at <u>2:18 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		M.D.		ADDRESS (Street, city or town, state) <u>219 S Washington St. 2701856</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>Easton, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Manuel E. Newman & Son</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>10/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. R. Neer</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Rev. 10-1-54

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. COLOR OF SKIN [REDACTED]		9. HIGHEST GRADE OF SCHOOL [REDACTED]		10. US BIRTH [REDACTED]		11. ALIEN STATUS [REDACTED]		12. SOCIAL SECURITY NUMBER [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]		16. CAUSE OF DEATH [REDACTED]		17. MANNER OF DEATH [REDACTED]		18. MEDICAL HISTORY [REDACTED]	
19. NAME OF PHYSICIAN [REDACTED]		20. NAME OF HOSPITAL [REDACTED]		21. NAME OF NURSE [REDACTED]		22. NAME OF CORONER OR EXAMINER [REDACTED]		23. SIGNATURE OF PHYSICIAN [REDACTED]		24. SIGNATURE OF CORONER OR EXAMINER [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF NEXT OF KIN [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]		29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. 1

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10689

10691

CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>ADELAIDE</u> Middle <u>P.</u> Last <u>STOCKWELL</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PORTLAND MAINE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN WESLEY STOCKWELL</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZA JANE MATHEWS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS. G.A. VANLENNP</u> Address <u>ST. MICHAELS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteroseptal Cardiovascular Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>23 May</u> , 19 <u>56</u> , to <u>30 October</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>30 October</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lowell Wroth</u>				ADDRESS (Street, city or town, state) <u>St. Michaels, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>R. Lowell Wroth</u>				DATE SIGNED <u>Nov. 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 2 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>MOSELYN PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hambleton Harrison</u>				ADDRESS <u>St. Michaels</u>			
24a. REC'D BY REGISTRAR DATE <u>Nov 1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Newbold H. Self</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10690

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>10 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova Florida 485-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Apalachicola</u>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Tadlock</u> Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 19, 1924</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>ARNNIE TADLOCK, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Viola Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>267-03-7862</u>		17. INFORMANT <u>Georgia Leetadlock, Cordova, Md</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO (b) <u>fract skull - Contre coup</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Blown head</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>struck on head</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>9-28</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cannery street</u>			
20f. (City or town) <u>Cordova Tal</u> (County) <u> </u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Louis S. Welty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-12-56</u>			
EXAMINER'S NAME (Type) <u>Louis S. Welty</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Apalachicola, Gen. Apalachicola, Fla.</u>			
22d. LOCATION (City, town, or county) <u> </u> (State) <u> </u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashwell, Easton, Md</u> ADDRESS <u> </u>					
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>N.R. Necker</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10681

CERTIFICATE OF DEATH

10691

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> 178-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>178-2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R. E.</u> Last <u>Turpin</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1881</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Turpin</u>		14. MOTHER'S MAIDEN NAME <u>Anna Emory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Rebecca W. Turpin</u> Address <u>Centerville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral thrombosis</u> (c) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Pathologist</u> , 19 <u>56</u> , to <u>9 A.M.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Centerville, Md.</u> DATE SIGNED <u>10/31/56</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Md., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>10/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Locust Hill Family Plot</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Barton Jr.</u> ADDRESS <u>Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>N. H. Newell</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682

CERTIFICATE OF DEATH

10692

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Careline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u> 05X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Washington</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 25, 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Randolph Washington</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Randolph Washington</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Failure</u> DUE TO (c) <u>2 days</u> 2 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital malformation of Heart</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 24</u> , 19 <u>56</u> , to <u>Oct 25</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. Baybutt</u> M.D.				ADDRESS (Street, city or town, state) <u>205 Park Ave Easton Md</u> DATE SIGNED <u>10/27/56</u>			
PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokers</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaie</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Heeren</u>	

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